INDIANA COMMISSION ON EXCELLENCE IN HEALTH CARE

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**September 30, 2004**
Meeting Time:	**1:30 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Gary Dillon; Sen. Allie Craycraft; Sen. Earline Rogers; Rep. Charlie Brown; Rep. Vaneta Becker; Rep. Timothy Brown; Amy Brown; Walter Daly, M.D.**

Members Absent: **Rep. Peggy Welch; Greg Wilson, M.D.; Michael Urban.**

Senator Miller (Chairperson) called to the meeting to order at 1:40 p.m. The Chairperson announced that the issue of bariatric surgery would not be addressed until the October 27, 2004 meeting. The topics of office-based sedation standards, childhood obesity, cultural competency, and the management of complaints against physicians would be discussed.

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[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Office-Based Sedation Standards

Libby Cierzniak, Member, Patient Safety Subcommittee, Baker & Daniels

Ms. Cierzniac explained the different types of office sedation procedures. There has been a huge growth in the use of in-office sedation for various procedures. Several states have reported patient deaths in plastic surgery procedures. The current rules governing sedation standards do not fit with modern practice. Many states have not regulated office-based sedation standards until they have encountered a problem. Currently, eighteen states regulate office-based sedation. She recommended that the Indiana Medical Licensing Board (Board) adopt rules governing office-based sedation.

Don Stogsdill, M.D., President, Indiana Society of Anesthesiologists

Dr. Stogsdill stated that his concern is patient safety in relation to the use of anesthesia. Some physicians who have little or no training or experience in sedation are working with anesthesia in an office based setting. Sedation is part of a continuum. A patient can slip between stages of sedation (e.g. light to deep sedation) easily and must be monitored to provide appropriate management of their care. Patients in deeper levels of sedation face additional risks. However, these risks can be managed if the proper personnel and equipment are in place. In the office setting it is particularly important to be well trained since this setting does not have the emergency backup that is found in hospitals or outpatient surgery centers. The Board needs to develop standards. There are already standards for hospitals and outpatient centers - physician offices that use sedation should provide a similar level of safety.

In response to questions from the Commission, Dr. Stogsdill stated that the rules do not need to address the type of surgical procedure being performed, only the sedation being used.

Mike O'Brien, Indiana State Medical Association (ISMA)

Mr. O'Brien stated that the issue of office-based sedation guidelines focuses on the future of the practice of medicine. Technology advances allow more procedures to be performed in outpatient settings. The ISMA doesn't think Indiana should over-regulate an issue just because another state had a problem. However, giving the Board the authority to regulate this area allows them to modify the standards as medical technology changes.

Robert Brandt, M.D., Member, Patient Safety Subcommittee, Past President, Indiana Society of Anesthesiologists

Dr. Brandt stated that this is a common sense issue. Dentists and better equipped facilities (i.e. hospitals and outpatient centers) have regulations regarding sedation but the use of anesthesia in an office-based setting is not regulated. If sedation is administered, oxygen, blood pressure, etc. should be monitored by a person who is not doing the actual surgery. Also, the appropriate equipment should be available in the office. A patient is entitled to quality care regardless of the setting in which the sedation is administered.

Jackie Rowles, CRNA, Past President, Indiana Association of Nurse Anesthetists

Ms. Rowles testified that there are 35,000 Certified Registered Nurse Anesthetists (CRNAs) in the United States. CRNA's are concerned about the safe use of sedation and anesthesia in office based settings. CRNA's have guidelines and checklists for their practice. A patient under deep sedation needs a trained person whose only responsibility is to monitor the patient and take care of any sedation problems that may arise.

Cornelia Hammerly, CRNA, President, Indiana Association of Nurse Anesthetists

Ms. Hammerly explained the differences between conscious sedation, sedation, and anesthesia. Registered Nurses, who are not CRNA's, are administering certain anesthesia without proper supervision or training. A person who administers anesthesia should not be the same person who provides the underlying procedure. Indiana has not issued any advisories on the administration of some new anesthesia products.

Childhood Obesity

Bill Wishner, M.D., Indianapolis

Dr. Wishner stated that obesity in children is a societal problem that will take 2-3 generations to correct. The ISDH has developed a long term plan to reverse the escalating trend in obesity. The plan focuses on prevention and includes the following components:

- Create an awareness of the problem, including early family education.
- Promote opportunities to change.
- Encourage appropriate legislation.
- Measure the trend of growth in children to identify overweight problems early.
- Coordinate prevention efforts between the government, business, education, and medical communities.

Mike O'Brien, Indiana State Medical Association (ISMA)

The ISMA has asked for legislation to curb childhood obesity for the past three years. Support for legislation to combat obesity has grown. Society is starting to move in the right direction but the problem has continued to get worse. Fast food restaurants are beginning to offer better choices, some schools are limiting access to vending machines, and employers are offering fitness incentives. Obesity is overtaking tobacco as the number one cause of death. Obesity increases a person's health care costs. A large scale state change is needed. Trying to offer healthy choices in school vending machines has met resistance. Vendors want to sell their products and schools like the revenue. Replacing unhealthy products with healthy choices is possible. Activity programs in schools should be another focus. There is an increased focus on core academic curricula that puts school time at a premium. Studies indicate that physical activity and healthy students actually increase test outcomes and increase the attention of students in the classroom.

Lisa Woods, Indiana Dietetic Association

Schools need healthy whole foods in the school environment. Improving children's health likely improves their school performance. Overweight children generally are absent from school at a higher rate than other children and experience higher health care costs and do not perform as well in school. Physical activity is linked to increased attention and test

scores. A child's nutritional choices in school should be from healthy options. Taxpayers should not have to accept the growing burden related to poor nutrition.

Mark Branch, Boys and Girls Club of Indianapolis

Mr. Branch stated that the Boys and Girls Clubs have programs that address youth obesity by offering healthy lifestyle activities. Most school and community programs are too short and focus on education activities. A successful program actively changes the child's lifestyle. Boys and Girls Clubs offer longevity. Kids come to these clubs usually 3-7 days each week. 97% of the kids self report that the Clubs help them implement a healthy lifestyle and habit.

Chuck Leer, President, Porter County Boys and Girls Club

The Porter County Boys and Girls Club serves 3,200 members and averages over 600 per day. Boys and Girls Clubs offer after school activities and are in a unique position to address the problem of obesity and healthy lifestyle. Children have many indoor options to occupy their time (e.g. video games, television, junk food, etc.). The Clubs have for years run physical fitness programs and other programs that address obesity and healthy lifestyle. Boys and Girls Clubs are already part of the solution and are in a good position to expand their activities to other kids.

Susie Borgnini and **Kelly Brown, RN,** Westfield Intermediate School

Westfield Intermediate School has created a "Walk Across America" program for the school's 5th and 6th graders. The program was developed to focus on the prevention of obesity through more physical activity outside of physical education classes and sports. Students log the number of steps they take each day (pedometers were donated by McDonalds). They received a grant from Anthem Insurance Companies to expand the program. Staff and teachers walk with the students. Prizes have been donated by local businesses to provide student incentives. Log sheets are collected and the information is tracked on an individual, a classroom, and a student body basis. Prizes are items that promote physical activity. The kids are enthusiastic. The number of miles that they walk is tracked on huge map of the United States and progress is updated on the map each week. The program is also looking at students who are not participating and trying to address how to get those kids involved. This program is fun for the kids and the teachers. Kids are invigorated when they return to class. The grant will end at the end of the school year and money to keep the program going will need to be found.

In response to Commission questions, Ms. Borgnini and Ms. Brown stated the following:

- The program takes place during the students' recess time which lasts about 30 minutes. There has not been an expansion of the school day. The recess time already existed in the schedule but not all schools have this kind of time available.
- Parents and siblings are encouraged to come in to walk with the kids during the recess break.
- The program began modestly in the Spring of 2003. This school year is the first full year. The Westfield School Board supports this program.
- The grant pays for the incentives and motivational items like the huge map and ribbons.
- They hope program will be expanded to other parts of the district.
- Teachers report that students are more focused after their walking time. They are

going to see if the program improves ISTEP scores. They are tracking the number trips students take to the health clinic, attendance rates, etc.
- Staff members have reported losing weight. Students may weigh in on a voluntary basis.
- Vending machines at the school are not available to students during the school day.

Cultural Competency

Calvin Roberson, MPH, MHA, Research Director, Indiana Minority Health Coalition

Mr. Roberson distributed his comments concerning cultural competency in the health care system to Commission members. (Exhibit #1) His presentation included the following points:

- Cultural competency in health care is the development and maintenance of interpersonal and professional skills to increase one's respect for, understanding of, and knowledge of the differences between patient and practitioner values, lifestyles, norms, beliefs, and opportunities that influence every aspect of the health care delivery system. Cultural competency is not the same as linguistic competency.
- Studies have shown physicians prescribing different treatment to patients based on the patient's race or gender.
- The ISDH created the Office of Cultural Diversity and Enrichment in 2001 to help address public health needs of minorities.
- The Indiana Minority Health Coalition has initiated and been involved in several cultural competency related initiatives (e.g. established a Division of Hispanic/Latino Health, created a cultural competency curriculum, etc.)

Mr. Roberson's recommendations included the following:

- Create a cultural competency curriculum that health care professionals would receive in school and at hospitals.
- Require cultural competency as part of continuing education for regulated health care professionals.
- Require that health service organizations use a formal mechanism for community and consumer involvement.
- Create a licensure process to ensure that interpreters are proficient.
- Ensure that a patient's primary spoken language and self-identified race/ethnicity are included on the patient's records.
- Increase the proportion of under-represented minorities among health professionals.

In response to questions by the Commission, Mr. Roberson stated the following:

- There is not a central place to report cultural competency issues and problems.
- The number of cultural groups in the state is rising. There are no programs that target all cultural groups but programs seem to expand as the need becomes present.

Zach Cattell, Legislative Liaison, Indiana State Department of Health (ISDH)

The ISDH Office of Cultural Diversity is providing cultural training. The class was developed to address problems that ISDH employees and contractors may have in interacting with minorities. Employees and contractors are required to participate in and complete the training courses. There are about 20 to 25 people per class and two classes are taught each month. Each class consists of a two day workshop. The initial class focuses on African-Americans, Asians, and Native Americans. A second class is available that includes other cultures (e.g. Eastern Europeans).

Management of Complaints Against Physicians

Ken Stall, M.D., Member, Patient Safety Subcommittee/Indiana State Medical Association

Dr. Stall indicated that the Patient Safety Subcommittee and the ISMA recommended changes to the physician disciplinary system in response to the frustration that patients and physicians have with the current process. The existing system takes a long time to either discipline or clear an accused physician. The Subcommittee examined other states' disciplinary laws and the Model Medical Practice Act (MMP Act) prepared by the Federation of State Medical Boards. Indiana's disciplinary laws, compared to the MMP Act, revealed good points in the existing law and gaps from the MMP Act. The Subcommittee used the MMP Act as the template for reform.

In response to the Commission on whether or not these proposed changes would expedite the complaint process, Dr. Stall stated that the proposed system would create more satisfaction for those who file a complaint.

Jennifer Thuma, Legislative Counsel, Office of the Attorney General

Ms. Thuma stated that the Attorney General's (AG) Office supports much of the Patient Safety Subcommittee's report (e.g. increase the use of administrative law judges, amend the standards for disciplinary actions, and create better tools to discipline physicians). However, the AG's Office does not support the consolidation of investigation and prosecution of complaints in the Medical Licensing Board (Board). Merging these functions would mean the Board would lose the ability have an independent review of the complaints. It currently takes about a year to investigate and prosecute a complaint. Several years ago the average time was about two years to process a complaint. The AG's Office already has a trained staff in place to work with all the boards under the Health Professions Bureau and the Professional Licensing Agency. Creating this function in the Board would require hiring and training additional staff.

In response to questions by the Commission, Ms. Thuma stated the following:

- That a complaint can be initiated with either the Board or the AG's Office.
- A person can be suspended through an emergency hearing in about two days.

Barbara McNutt, General Counsel, Health Professions Bureau (HPB)

Ms. McNutt stated that the HPB works with 24 different boards and over 40 different types of licenses. The recommendation by the Patient Safety Subcommittee is targeted solely at the Medical Licensing Board. Under this proposal the HPB and the AG's Office would have to work under a bifurcated system. The AG's Office would continue work with all the other health professions while the Medical Licensing Board would have possess the functions of

the AG's Office (e.g. an investigation unit, etc.). Administrative law judges (ALJs) are already being used for hearings. The suggestion that a pool of ALJ's be created and that ALJ's decisions be final would work if additional funding and training is available. The investigation of a complaint is usually the part of the process that takes the most time. Also, IC 16-21-2-6 needs to be amended to prompt hospitals to report disciplinary actions taken against physicians. Ms. McNutt noted that the program for impaired health care professionals is not state funded. HPB receives a federal grant for monitoring of impaired health care professionals.

In response to Commission questions, Ms. McNutt stated that if the Patient Safety Subcommittee's recommendations were followed the time to prosecute a complaint may still be about a year. The investigative process is time intensive. However, additional resources devoted to the investigative process may help speed up the process.

During discussion among Commission members the following points were made:

- The Pharmacy Board has investigators who inspect pharmacies. Medicaid Fraud Unit investigators are often law enforcement officers. The AG's Office uses attorneys who are Registered Nurses to investigate complaints against health care professionals.
- Hospitals have a statutory duty to report impaired physicians but the law is not apparently being enforced.
- Many times the AG's Office finds out about a hospital's action against a physician through the National Practitioners Data Bank, not the hospital. By the time the information reaches the AG's Office through the Data Bank much time has lapsed, which hampers the investigation.
- Physician licensing fees raise about $5M for the State General Fund over a two year period.

The Chairperson asked the Health Professions Bureau, Attorney General's Office, Indiana State Medical Association, and any other interested parties to resolve some of these issues informally.

The Chairperson adjourned the meeting at 4:00 p.m.